Sexual Violence Against Women in Lesotho

A collaboration between:

MEASURE Evaluation Project, Tulane University

Sechaba Consultants, Lesotho

CARE, Lesotho

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Executive summary

This report presents findings on the nature and magnitude of sexual violence in Lesotho, as well as outcomes of the Sexual Health and Rights Promotion (SHARP!) project, a USAID funded activity of the Regional HIV/AIDS Program for Southern Africa (RHAP-SA) that addresses sexual violence in Lesotho. SHARP! is implemented by CARE Lesotho-South Africa. The primary goal of the study was to determine the nature and magnitude of sexual violence. In addition, the study also provided an opportunity to compare program and non-program areas. Since a baseline survey was not conducted when SHARP! began in April 2001, this cross-sectional study cannot attribute any differences found between program and non-program areas to SHARP! The study does permit an examination of exposure to SHARP!, knowledge and perceptions of SHARP! and several outcomes potentially influenced by exposure to SHARP!, such as differences in the definition and reporting of sexual violence. A qualitative component conducted as part of the assessment also permitted exploration of sexual violence and perception of the appropriateness and utility of SHARP! activities. A follow-up survey conducted in the next 1-2 years would greatly strengthen the evaluation of SHARP!

> The primary goal of the study was to determine the nature and magnitude of sexual violence.

In this report, sexual violence refers to any type of assault (attempted or completed forced sex) or coercion (the use of pleading, blackmail, threats, trickery and/or intimidation to obtain unwanted sex). Sexual assault and sexual coercion are considered to be mutually exclusive categories of sexual violence. Each is discussed separately in this document.

Data collection consisted of qualitative and quantitative components. The qualitative component consisted of six focus group discussions and 21 in-depth interviews. The quantitative component consisted of a random household survey conducted in selected neighborhoods of Maputsoe and Maseru. Half of the neighborhoods were SHARP! program areas and half were non-program areas. A total of 1,049 women were interviewed. Approximately equal numbers of survey respondents resided in program areas (49%) and non-program areas (51%).

Summary of Findings

- Reporting of sexual violence is common: 61% of the sample reported having experienced sexual violence at some point in their lives. Forty percent reported experiencing some form of coerced sex and 50% experienced sexual assault. Twenty-two percent (22%) of the sample reported being physically forced to have sexual intercourse at some point in their lives.

- Local definitions of rape underestimate actual occurrence of sexual violence. The local definition of rape is sexual assault by strangers upon virgins. Sexual assault by someone the woman knows and sexual assault upon a sexually experienced woman are not considered rape.

- A woman's decision to disclose an assault is dependent on the type of perpetrator; disclosure is more common if the perpetrator was a stranger.

- Community members are typically not supportive of women who report having been sexually assaulted and often blame the woman for causing the assault;

- Few women who experienced sexual violence sought out existing services;

- Many women choose not to report sexual violence to the police because they face harsh and accusatory questioning from the male officers;

- More women in the program areas were familiar with SHARP! than in non-program areas;

- Women in program areas were more likely to report experiences of sexual violence to authorities, although the level of sexual violence in the two areas did not differ. This may indicate greater awareness or empowerment of women in the program areas to seek help.

Programmatic Recommendations

♀ Continue and expand program on sexual violence

Findings illustrate that SHARP! addresses an important need and is perceived as a positive and effective program. Therefore SHARP! should continue to focus on sexual violence issues as part of their overall HIV prevention program and develop meaningful goals and objectives for addressing this issue. Development of specific goals and expected program outputs and outcomes would assist the program in focusing efforts and monitoring progress.

♀ Empower selected Peer Educators (PEs) to serve as local sexual violence resources

Selected PEs should receive training on reporting of sexual violence and medical and judicial procedures, as well as receiving information about available community services (i.e., support groups).

♀ Continue to address sexual violence issues with youth

Targeting youth, especially male youth, with messages on negative consequences of sexual violence are particularly important, since dating relationships seem to pose the greatest threat of sexual violence. Discussions and information that challenge traditional stereotypes are important as youth begin to develop norms regarding gender roles and relationship expectations.

♀ Use culturally appropriate classifications of sexual violence

Too often, sexual violence programs focus on rape, rather than sexual violence more broadly. Given the very narrow definition of rape in Lesotho, messages about rape will not resonate with the vast majority of women who experience forced sex. Discussions pertaining to sexual violence should move beyond rape, to include other forms of sexual assault and, as well as sexual coercion.

♀ Strengthen advocacy efforts and awareness of legal rights

Advocacy efforts to strengthen the legal structure and standardize sentences and procedures could build trust in the system and increase reporting of sexual assault. In addition, increased awareness is clearly needed, especially since many women reported uncertainty about how and where to report a sexual assault. Women often stated that they were unaware of any organizations responsible for assisting survivors of sexual violence.

♀ Concentrate program efforts within the community, not in formal service systems

Most women who reported having been sexually assaulted are not reaching out to the police station or hospitals due to insensitive treatment and fear of public disclosure. SHARP! can work toward helping community members recognize all forms of sexual violence and to become committed to reducing its occurrence. At present, efforts focused within the judicial or health care system are likely to assist only the small number of individuals with the courage to seek out these services.

♀ Continue to develop promotional materials endorsing women's rights & support of survivors

About 95% of the respondents who were aware of SHARP! reported exposure to program materials, such as hats and t-shirts. These items provide more than program recognition. They also provide reminders of the threat of HIV and, in some cases, the need to use condoms. Messages about sexual violence may have a similar effect and may help to break down norms that contribute to sexual violence. Appropriate slogans would need to be developed locally, but may include some of the following themes mentioned by SHARP! program staff and other concerned individuals: "Stop the violence," "I support, I don't judge," "I have the right to say no," and "Real men wait until she says yes."

♀ Tackle gaps in AIDS knowledge

Although general awareness of HIV is high, there are a number of specific gaps in knowledge that may be contributing to violence and transmission. Specific beliefs, such as the 'cleansing myth' and the idea that AIDS does not exist, need to be addressed. More people need to realize that a healthy looking person can carry the virus and that it cannot be transmitted from mosquito bites or common inanimate objects. Also evident are the gaps in knowledge surrounding MTCT and HIV transmission through breastfeeding, symptoms of STDs, and the incubation period of HIV.

♀ Include males

Men of all ages need to be involved in programs aimed at preventing violent behavior through school life-skills programs, community theatre,

Introduction

1.1 Background of the study

Since 1999, the USAID funded Regional HIV/AIDS Program for Southern Africa (RHAP-SA)[1] has implemented prevention interventions with high-risk populations moving through and residing in border towns in 10 Southern African countries, including Lesotho, Malawi, South Africa, Swaziland, Zambia, and Zimbabwe. The RHAP-SA program is implemented by FHI/IMPACT, PSI/AIDSMARK, the Policy Project and local implementing agencies such as CARE-Lesotho, working at selected border sites. The MEASURE Evaluation Project conducted the present study as part of its mandate to evaluate the RHAP-SA program, in collaboration with Sechaba consultants, a local research organization.

1.2 HIV and Sexual Violence in Lesotho

> I not only had to cope with the rape-with the violation of my body, but also with the possibility that the man had infected me with HIV.[2]

The ability of women to protect themselves from HIV infection through abstinence or condom use is hindered by sexual violence perpetrated against women. In many countries, such as Lesotho, where nearly a third of the population is infected with HIV, and where gender inequalities, migrant work and cultural acceptance of some forms of non-consensual sex exist, sexual violence is assumed to contribute to the rapid progression of the epidemic. Prior to this study, however, the magnitude of this sexual violence had not been measured in Lesotho.

Studies have demonstrated that women who have experienced sexual assault in their childhood or adolescence are more likely to engage in behaviors that put them at risk for HIV, such as prostitution, sex with unfamiliar partners, low rates of condom use, and alcohol and drug use. A woman's economic vulnerability, for example may put her in the position of consenting to unwanted sex with a partner because of fear that financial support will be withdrawn. Verbal coercion in this environment further undermines a woman's ability to refuse sex. Men may use their position of authority

[1] *RHAP-SA, has also been called Corridors of HOPE.*
[2] *Charlene Smith, South African Journalist who after having been raped in 1999, campaigns on behalf of other survivors.* www.news.bbc.co.uk/1/hi/world/africa/545305.stm

as an employer or school faculty to extort sex. These scenarios illustrate how gender inequalities undermine a woman's ability to control her sexuality and increase her risk of sexual assault.

Recent studies have been pivotal in drawing attention to the problem of sexual violence in developing countries (Jewkes, 2002). Although much of the research on sexual violence has been conducted in Southern Africa, very little is known about the situation in Lesotho. Lesotho has one of the highest HIV rates in the world. In 2001, UNAIDS estimated that 31% of Basotho adults age 15-49 were living with HIV, compared to 26% in 1999 (UNAIDS, 1999). A person in Lesotho who turned 15 has a 74% chance of becoming infected with HIV by his or her 50th birthday (US Global Report, 2002). As in many countries of Southern Africa, women are more likely to be infected with HIV than are men (UNAIDS, 2002). A recent investigation, conducted by the Basotho NGO Women and Law in Southern Africa (WILSA), focused on how sexual violence was "perceived and dealt with in different structures of justice delivery where it is reported and adjudicated" (Chaka-Makhooane, et al, 2002). This study found severe difficulties with the reporting of sexual violence. In another study, by CARE-Lesotho, an analysis of qualitative data suggested that sexual violence was widespread and that it impeded a woman's ability to protect herself from HIV infection. Although these investigations provide useful information, much remains unknown about the magnitude, severity and context of sexual violence in Lesotho.

More information is needed about how to reduce sexual violence. Specifically, research is needed to identify the factors that contribute to the incidence of sexual violence, perceptions and local etiology of sexual violence in order to guide intervention strategies. This study aims to fill some of the gaps that exist in current research.

1.3 Objectives of the study

This study was undertaken to explore the nature and magnitude of sexual violence in Lesotho. In addition, the study collected information on the effects of the Sexual Health and Rights Promotion (SHARP!) program. The comparison of program and non-program areas provides some evidence about potential effects of the program. However, this single cross-sectional study does not permit the attribution of differences between program and non-program areas to program effects. Finally, this study investigated a range of HIV risk behaviors and knowledge levels. The specific study objectives were:

1. To estimate the magnitude of sexual violence among Basotho[3] women;

2. To gather descriptive data on the most common types of sexual coercion and assault experienced, such as general identifications of the perpetrators, and the age of first coercive and/or sexual assault experience;

[3] *'Basotho' is the term used to refer to the citizens of Lesotho.*

3. To explore the cultural context of sexual violence, including definitions, reasons for violence against women, and public response to disclosure of sexual violence;

4. To assess whether women who have experienced sexual violence are more likely to engage in behaviors that put them at increased risk of HIV/STD;

5. To gather intervention-specific information, such as exposure to SHARP!, the response of the judicial system, and suggestions for initiatives to assist women;

6. To assess differences between SHARP! program and non-program sites with regard to the level of sexual assault and sexual coercion and related attitudes;

7. To assess differences between program and non-program sites with regard to HIV and STD knowledge, sexual activity and condom use.

1.4 Overview of SHARP!

The SHARP! program is a cross border initiative implemented by CARE Lesotho-SA. ... unique features are present at each site.

The Sexual Health and Rights Promotion (SHARP!) program is a cross border initiative implemented by CARE Lesotho-South Africa. SHARP! is active in three border towns of Lesotho, namely Maputsoe, Maseru and Mafeteng.[4] Complementary activities are also implemented in the towns of Ficksburg and Ladybrand in South Africa (bordering Maputsoe and Maseru respectively). Although the SHARP! interventions follow the same guiding strategies, unique features are present at each site. Project components are described below. As the present investigation is limited to RHAP-funded sites in Lesotho, only the activities within Maseru and Maputsoe are described.

The overall goal of SHARP! is to protect and promote the livelihood security of individuals and households affected by HIV/AIDS.

Specifically, the program has five objectives:

1. Reduce HIV/AIDS vulnerability of households by increasing the safety of sex among youth and other priority groups;

2. Improve the capacity of community based organizations (CBOs) and enhance their ability to provide comprehensive care for people living with HIV/AIDS;

[4] *Mafeteng is funded by BMS/STF, not the RHAP program. Therefore this site was not included in the present investigation.*

3. Improve the ability of service providers to identify, understand and respond to the reproductive health needs of priority groups;

4. Establish Resource Centres in Maputsoe and Maseru;

5. Pilot home based care activities.

CARE-Lesotho employs a number of strategies to meet the above objectives. In an effort to reach marginalized groups in the community, peer educators (PEs) are recruited and trained. Training for PEs includes education regarding HIV transmission, HIV/AIDS prevention, symptoms of STDs and available treatment options, as well as skill building in condom promotion and negotiation. PEs are also sensitized to issues of sexual violence and are encouraged to raise awareness and promote discussion of sexual violence. PEs are also provided simple legal training related to laws, reporting procedures and helping survivors seek legal recourse. The program commenced in May 2001, and is continuing to expand. For instance, in March 2003, 141 PEs were active in Maputsoe and another 177 were operating in Maseru. In the six months prior to April, PEs in Maputsoe and Maseru hosted more than 8,400 group behavior change meetings (BCM) each.

In order to expand the response to HIV/AIDS prevention and mitigation, a key strategy of SHARP! is the establishment of community HIV/AIDS Resource and Information Centres in the Maputsoe and Maseru sites. Maseru recently acquired temporary premises for the Centre in March 2003. The Resource Centre in Maputsoe has been operational since August 2002. Existence of such a Centre provides unique opportunities to broach HIV and sexual violence issues. For instance, staff and PEs are available at the Centre to provide information and have personal discussions with clients. The Centre also aims to improve linkages between service providers and the community. Specifically, SHARP! has developed a relationship with the local police force in Maputsoe and an officer is available at the Centre once a week to respond to complaints and questions. The officer is also equipped to deliver information on women's rights and related laws, advice on how to protect oneself from sexual violence and on how to report sexual assault.

Further efforts to prevent HIV include SHARP!'s activities to increase access to condoms. Free condoms are provided through the Resource Centre in Maputsoe, PEs at both sites distribute condoms and program staff have established a number of free local outlets. Free outlets include such places as the police station, the homes of the village chiefs, border posts and local venues. Through all of these approaches, SHARP! regularly distributes a large number of condoms. For example, during an eight month period the Maseru site was responsible for distributing an average of 29,877 condoms.

This study was undertaken in an effort to help SHARP! evaluate their effect on sexual violence and to provide further information that will assist them to more effectively address this problem.

Methodology

2.1 Definitions of sexual violence

The study did not provide a definition of sexual violence to the respondents. The purpose of the study was to explore women's perception of sexual violence and the frequency of different types of sexual events or experiences. The results of the focus groups allowed the researchers to determine which events were us define sexual violence from the respondents' perspective. The survey allowed us to measure the levels of different sexual experiences whether or not the respondents considered it violent.

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2.2 Study Design

This study was designed to estimate the level of sexual violence in two Lesotho towns and to assess the progress of the SHARP! program, using both quantitative and qualitative methods. Focus group discussions and in-depth interviews were conducted first, followed by a random household survey. Since no baseline data were available, a non-equivalent group posttest only design was used.

The qualitative data were collected through six focus group discussions (FGDs) and 15 in-depth interviews with women of different age groups in the community. Arrangements to carry out two of the FGDs were made through *'Selibeng',* an organization that deals with intimate partner violence in several areas of Lesotho. The other four FGDs were arranged with assistance of the SHARP! program In each of the FGDs, 9-12 women/female youth were asked to participate.

Respondents for in-depth interviews were identified primarily by local village chiefs and SHARP! staff. Approximately half of those interviewed were 18-25 years of age and the other half were 26-35.

An additional six interviews took place with survey participants who had reported to interviewers that they had experienced forced sex. The interviewers were asked to use their best judgment to determine whether a woman who reported experiences

of sexual violence during the survey would be willing to speak more extensively about her situation. If the respondent said that she would be willing to participate in an in-depth interview, the interviewer informed the Field Coordinator who subsequently visited the woman and scheduled an appointment.

All focus groups and in-depth interviews were tape-recorded and transcribed verbatim in the local language. All transcriptions were then translated into English for analysis. Each interview and focus group was attended by two members of the field team: the Field Coordinator who led the interview/focus groups, and an assistant who took field notes, managed the recording, and transcribed the text.

Following the qualitative data collection, a random household survey was conducted of women aged 18 – 35 living within selected neighborhoods of Maseru and Maputsoe, the two largest cities in Lesotho. A total of five communities were purposively selected for inclusion in the study. The program communities were selected from SHARP!'s "focal" sites, including Ha Mathata within Maputsoe town and two areas within Maseru—Thibella and Thetsane. Comparison communities with characteristics similar to the SHARP! program sites were then selected: Motimposo in Maseru and Hleoheng in Maputsoe.

Mapping and enumeration of households was conducted in each of the selected communities to provide an accurate sampling frame. Within each community households were then selected using systematic random sampling. At the household level, one woman in each household was randomly selected for an interview. Selection entailed recording the initials of all eligible women on slips of paper, folding them, and putting them into a bag. Two additional visits were made before the woman was considered as a non-response. 1109 households were approached to participate in the research and a total of 1049 interviews were completed. The study was conducted from February to July 2003.

There is little previous research on violence against women in Lesotho upon which to estimate sample size, but several studies on this issue have been conducted in South Africa. Surveys there have confirmed an alarmingly high incidence, about 28%, of forced sexual initiation among young South African women (Wood, Maforah and Jewkes, 1998). Using these studies as general guidance, we estimated that 30% of Basotho women have experienced forced sex at some point in their life. Concerns related to cost and the magnitude of intervention effect was also considered in determining sample size. Finally we calculated a sample size to demonstrate a 10% difference in forced sex between program and comparison sites. At 80% power for detecting this difference, an alpha level of .05 and a design effect of two (to account for pre-selection of sites), total sample size equaled 924. To achieve this final sample size we estimated a 20% non-response rate.

To minimize under-reporting of assault and coercion, the questionnaire included a series of specific questions about the experience of different types of sexual violence and several scenarios in which sexual violence could occur. Thus, rather than asking

respondents whether they had ever been raped, they were asked about the occurrence of forced sex. Similarly, in exploring coercion, respondents were probed about particular circumstances, such as if a teacher ever threatened them with bad marks if they did not agree to sex. This approach was adopted because qualitative research had demonstrated gaps between the local definition of sexual violence and the definitions adopted by the research community. Specifically, the local community had a very narrow definition of rape (only applies to virgins sexually assaulted by strangers), whereas the research community generally considers any instance of forced sex to be rape. By asking women about specific types of experiences, rather than just asking them about rape, we believe that we came closer to the true level of sexual violence in Lesotho.

The questions relating to sexual assault examined incidents involving both sex and sex related acts, whereas coercion focused only on sex. "Sex related act" and "sex" are defined below and were explained to participants.

- Sex is defined as contact between the penis and vulva, or the penis and the anus involving penetration, however slight; contact between the mouth and the penis, vulva or anus; or penetration of the anal or genital opening of another person by a hand, finger or other object.

- Sex related acts involve the giving or receiving of touching, rubbing, kissing, grabbing or fondling, as well as other behaviours the respondents perceive as sexual (i.e., stripped of clothing).

Respondents were given these definitions in the survey.

Training and selection of survey field team

Sechaba Consultants provided the field coordinator and recruited two supervisors and ten female interviewers. Criteria for selection were interviewers who were non-judgmental and mature and who were adept at interacting with all classes of people, building rapport, and dealing with sensitive issues.

Interviewer training focused on learning to administer the questionnaire and field preparation. Training exercises included role-playing, mock interviews, discussions regarding the research protocol and ways to address sensitive issues that could arise during the interview.

Supervisors attended the training and received additional guidance on their role, as well as information about sampling techniques, mechanisms for supporting interviewers, following up on non-responses, quality control procedures (including spot checks and disciplinary actions) and responding to women requiring assistance.

In recognition of the emotional difficulties associated with recording women's experiences of sexual violence, a number of mechanisms were adopted to address field interviewer needs. During the interviewers' training process, issues regarding sexual violence were openly discussed and participants were provided the opportunity to withdraw from the project at any time. During the research, regular debriefing meetings were held to enable the research team to discuss what they were hearing, their feelings about the situation and how it was affecting them. These meetings aimed to reduce the stress of conducting the field interviews and to avert any negative consequences.

Quality Control and Data Management

A range of mechanisms were used to monitor the quality of the survey implementation. Supervisors reviewed each of the questionnaires upon completion, identifying inconsistencies and skipped questions. The Field Coordinator reviewed a sample of questionnaires at the completion of each day's fieldwork. Data entry occurred immediately after the Supervisor and Field Coordinator had reviewed the questionnaires. And, all data were entered twice and any discrepancies found between the two resulting datasets were resolved by reviewing the original questionnaire.

Data Analysis

Chi-squares for categorical variables and independent sample t-test for continuous variables were used to assess the association between sexual violence and the independent variables. The term 'significant' as used below refers to the result of a statistical test showing a probability value (p-value) of .05 or less.

2.3 Ethical Considerations

To ensure participants' privacy, this investigation utilized the WHO's recommended ethical guidelines for studies on violence against women (WHO, 2001). Specifically, investigators were prepared for many reactions the community might have to this study and the emotional risks faced by participants as they recalled frightening, humiliating or extremely painful experiences. Particular care was taken to ensure that all questions about violence and its consequences were asked in a supportive and non-judgmental manner. This was achieved through the careful selection and training of interviewers and through the design of the questionnaire. Interviewers were trained to terminate the interview if the participant appeared to become too agitated. Moreover, questionnaires were designed to carefully introduce the subject of sexual violence and to inquire about women's experiences of violence in a sensitive manner. For example, the introduction to the section exploring sexual violence began with an introduction that highlighted the sensitivity of the topic, carefully stated the reasons for the study and assured the respondent that all information would be treated in a confidential and non-judgmental fashion. Furthermore, the study was framed as an investigation of women's health and life experiences, rather than just a study of sexual violence.

Additional measures were taken to protect the confidentiality of participants' responses including anonymous questionnaires; no interviewer conducting an interview in her own community; only conducting interviews in a private setting; and terminating or changing the subject if an interview was interrupted by anyone.

All participants were informed of available sources of help. The Field Coordinator assisted in producing a resourcelist of agencies and individuals who could provide support both during and after the survey. This information was read to all participants, regardless of whether they disclosed experiencing sexual violence or not.

To ensure participants' privacy, this investigation utilized the WHO's recommended ethical guidelines for studies on violence against women (WHO, 2001).

The research team was also committed to ensuring voluntary participation in the study and there were no incentives for participation. At the beginning of all interviews, participants were informed orally of the purpose and nature of the study and told that the survey included questions about highly personal and sensitive topics. Consistent with the questionnaire format, interviews were conducted in the local language. To ensure anonymity of the participants, only verbal consent was requested. The interviewer recorded on the questionnaire that the consent procedure had been administered, and noted whether permission to conduct the interview was granted.

2.4 Limitations of the study

There are three limitations that the reader should keep in mind when interpreting the results from this study. First, although the respondents in the quantitative survey were randomly selected, the areas from which they were drawn were not. Thus, these estimates cannot be generalized to all of Lesotho, or even to the two cities where the study took place, Maseru and Maputsoe. These findings represent the incidence within the areas of Thibella, Ha Mathata, Thetsane, Motimposo and Hleoheng.

Second, recall bias is a common problem in surveys that address sensitive topics such as sexual violence, particularly child sexual abuse. However, the fact that 23% of this sample reported experiencing forced sex when they were 16 years of age or younger, suggests that this may not be a serious problem in this survey.

Finally, the respondents in the study were limited to women. Men were excluded because of limited resources and time, and because the researchers focused on estimating the magnitude of sexual violence as experienced by women. Future research should explore male perspectives on sexual violence.

Results

3.1 Characteristics of study population

A total of 1,049 interviews were completed, 514 were from SHARP! program areas and 535 from non-program areas. Table 1 presents the demographic characteristics of the women sampled. No significant difference between the program and non-program areas was found for mean age, where participants spent their childhood, level of education or ownership of select consumer goods. However, there were significant differences in the distribution of religion, marital and employment status, type of employment, type of toilet and house building material for the two samples, suggesting those living in the program areas have higher SES than those in non-program areas. However, subsequent analyses found no relationship between the SES variables and sexual violence (discussed later in this section).

There were slightly more evangelicals and fewer Catholics in the non-program areas as compared to program areas ($p = .001$). Employment status and type of employment were also significantly different for program and non-program areas ($p<0.000$ and $p=.036$ respectively). Women sampled in program areas were more likely to be employed and those employed were to be factory workers. Employed women in non-program areas were more likely to be domestic worker, street vendor/hawker/casual worker, or other. In addition to being employed, 14% of women (16.3% from program areas and 11.5% from non-program areas—$p<0.025$) reported having extra sources of income, such as a pension or money from their family. (Data not shown)

A number of socio-economic indicators were used as proxies to measure wealth among the respondents. Interviewers reported on the building material of the respondent's house and type of latrine and respondents were asked whether or not they owned particular assets, ranging from a radio to a car. Significant differences between program and non-program areas were observed for the type of toilet owned ($p= .000$) and the type of material in which their house was constructed ($p= .000$). In addition, respondents in the program areas were more likely to have VIP latrines and to reside in housing made of cement bricks.

Table 1 Distribution of respondents by select sociodemographic characteristics and location of residence

	Program areas (N=514)	Non-program areas(N=535)	Total (N=1049)	p-value
Mean age yrs (mean SD)*	24.56 (5.23)	24.84 (5.51)	24.70 (5.37)	*NS*
Age categories				*NS*
18-25	63.4	49.2	61.2	
26-35	36.6	53.8	38.8	
Childhood residence (to age 15)				*NS*
City	14.6	11.0	12.8	
Town	27.6	32.3	30.0	
Rural/farm	57.8	56.6	57.2	
Religion				*.001*
Catholic	49.1	39.4	44.2	
Protestant	33.7	35.3	34.5	
Zionist/Pentecostal/other	17.3	25.2	21.4	
Education				*NS*
Std 1-7 or no ed**	41.4	44.9	43.2	
Form A – C	39.5	37.0	38.2	
Form D and beyond	19.1	18.1	18.6	
Marital/relationship status				*.011*
Married/cohabiting	44.9	48.2	46.6	
Single	39.5	32.5	35.9	
Separated/divorced/widowed	12.1	12.0	12.0	
Boyfriend(s)	3.5	7.3	5.4	
Currently employed	51.6	37.8	44.5	*.000*
Type of employment				*.036*
Factory worker	67.9	55.4	65.2	
Domestic worker	11.7	13.4	12.4	
Street vendor/hawker/casual	7.2	11.9	9.2	
Other***	13.2	19.3	15.8	
Consumer goods owned				*NS*
Radio	76.5	77.2	76.8	
Television	30.2	32.9	31.6	
Phone	28.4	28.6	28.5	
Refrigerator	19.5	20.2	19.8	
Car	3.9	6.5	5.2	
Type of toilet owned				*.000*
W/C flush	3.7	3.4	3.5	
VIP with fly screen	25.3	15.3	20.2	
VIP without fly screen	10.5	9.5	10.0	
Ordinary latrine	52.5	65.4	59.1	
None	8.0	6.4	7.1	
House Building Material				*.000*
Cement Bricks	87.7	80.4	84.0	
Mud	4.3	12.5	8.5	
Other	8.0	7.1	7.5	

* Standard deviation
** Only five respondents had no formal education, (2 in program and 3 in non-program area)
*** Includes civil servant, shop worker, salon/hair dresser and sex worker

3.2 The magnitude of sexual violence among Basotho women

The survey data found that 61% of respondents reported having experienced sexual violence at some point in their lives. Forty percent reported experiencing some form of coerced sex and 50% experienced assault. Twenty-two percent of the sample reported being physically forced to have sexual intercourse at some point in their lives.

The findings in this section are presented separately for sexual coercion and sexual assault. In this study, only those scenarios that explicitly refer to attempted or actual forced sex or non-penetrative sex acts involving physical violence are considered as sexual assault. Again, the local community defines rape very narrowly (only applies to virgins sexually assaulted by strangers), whereas the research community generally considers any instance of forced sex to be rape. In this report, we present the local definition of rape. By asking women about specific types of experiences of sexual violence, rather than just asking them about rape, we believe that we came closer to the true level of sexual violence in Lesotho.

Sexual Coercion

Table 2 presents the incidence of sexual coercion reported by the study respondents. Forty percent of the women reported experiencing some kind of coerced sex. Consent to unwanted sex due to fear of violence or other consequence is the most frequently reported type of coercion (20.5%). Approximately 17.8% respondents reported sex in response to a partner's continual arguments. The incidence of other coercive episodes, such as sex in return for transport or for money or gifts, was reported by less than 10% of respondents.

Table 2 Respondents reporting sexual coercion and ultimatums by type of coercion (N=1049)

	%
Ever experienced coercion (any type)	*40.5*
Ever experienced coercion by specific type:	
Sex because of fear of violence or other consequence	20.5
Sex pressured by arguments	17.8
Sex because of wanting money or gifts	9.0
Sex for fear of losing money/gifts	7.9
Employer insisted sex prior to employment*	5.4
Ever had sex when she didn't want to	4.9
Sex with man threatening to end relationship	3.9
Sex with man threatening to cease her employment**	2.9
Any teacher threatened bad results if she refused sex	2.7
Sex with a man who had provided transport	1.8
Sex because of being too drunk to stop him	1.6

* Excludes 69 respondents who had never tried to obtain employment.
** Excludes 125 respondents who had never been employed.

While only about 8% stated that they had consented to unwanted sex due to fear of losing money or gifts, this scenario was commonly mentioned in the in-depth interviews and focus groups:

> If a husband is a breadwinner, he usually demands to have sex, otherwise he refuses to leave money for the supplies.
>
> If a woman denies her husband sex, he would stop giving her his salary; in fact, he would divert it to other people who satisfy his sexual needs. In essence, the woman would be left with no cash to feed their children or to provide clothes for them.

Survey respondents also reported sexual ultimatums by men in positions of authority. Among those who had searched for work in the past, 5% revealed that a potential employer had insisted upon sex before hiring her, among whom 28.1% agreed to sex.

Qualitative data suggest that, when considering the alternatives, consenting to sex was rationalized as advantageous. Some women reported that consent served to protect them against STDs:

> He will go out and look for someone else to satisfy his needs. In case that someone had an STD then she would infect the husband who would then infect the wife.

Consent also shielded women from physical abuse. As one FGD participant stated:

> Most of the time one would have sex just so the husband would stop abusing her.

In response to an open-ended question about the consequences of refusing sex with a steady partner, more than 32% of survey respondents reported that they would be beaten and 36.5% said they would be forced. This is reinforced by one women's statement that,

> Given men's strength, struggling would be a futile exercise.

Sexual Assault

Respondents were asked how they would describe their first sexual experience by selecting from four one-line scenarios, ranging from "I was willing" to "I was raped." The question was asked early in the interview before sensitizing introductions to sexual violence. This provides a lower parameter for the estimate of sexual violence, since some women may not have felt comfortable responding. Nearly 10% indicated that sexual initiation involved force and 1.4% reported that they were raped. (See Table 3) Almost a third of respondents, reported having been "tricked" into their first sexual experience. Respondents were not given a specific definition of rape, therefore they responded based on the local definition (only applies to virgins assaulted by strangers).

Table 3 Distribution of respondents by description of first sexual experience (N=939)

	%
I was willing	56.2
I was tricked	32.7
I was forced	9.7
I was raped	1.4

The different types of sexual assault experienced by respondents are reported in Table 4. Approximately 22% of the total sample report experiencing forced sex at some point in their lives, with 16% experiencing forced sex in the past year. One woman reported forced sex 10 times in the last year. More than 29% of respondents indicated that they had been touched against their will, with more than one-third indicating that they had experienced the event in the past year. Of the 13% who reported attempted forced sex, 27% experienced attempted forced sex in the past year. Ten percent indicated that they had been forced to touch a man's genitals and nearly 42% of them reported this event occurred within the previous year. When asked whether they had ever been forced to do anything else sexual that they found degrading or humiliating (i.e., stripped of clothing, forced to undress), 7% responded affirmatively.

Table 4 Distribution of respondents reporting ever experienced sexual assault by type and timing

	Ever experienced (N=1049)	*Among those who ever experienced the event, the number and percentage who experienced the event in the previous year*	
Type of assault:	*%*	*(N)*	*%*
Forced sex	22.6	(N=235)	16.2
Touched against her will	29.4	(N=308)	31.5
Forced to touch a man's genitals	10.0	(N=105)	41.9
Forced to participate in any other degrading sexual activity	7.0	(N=73)	51.7
Attempted forced sex	13.0	(N=136)	27.2

Respondents were also asked about the forced sex and rape experiences of their sisters and other community members. These questions were included to permit third-party reporting, or displacement of personal experiences. As one of the focus group participants stated, women often "relate stories as if they happened to other people when in actual fact those things happened to them."

3.3 Characteristics of coercion and assault experienced

Description of the perpetrators and female's age at time of event

For all types of coercive and sexual assault experiences reported, women were asked their age at time of first occurrence. In the cases involving forced sexual experiences, women were also asked to identify what type of relationship, if any, she had with the perpetrator. The results are listed in Tables 5 and 6.

Table 5 Respondent's reported age, in years, at first forced and/or coerced sexual experience

Experience	*(N)*	*Range*	*Mean*
Forced Sex	236	7-34	19.5
Attempted Forced Sex	136	12-34	19.4
Touched against her will	308	8-35	21.1
Sex because she was afraid	215	13-35	20.8
Sex pressured by arguments	187	12-34	21.1
Sex because she wanted money/gifts*	87	15-35	24.2

* For 7 respondents, the age at which the event occurred is missing.

The mean age of first forced sex was 19.6 years. Of these women, the majority (73%) reported that the perpetrator was their former or present intimate partner. Other common perpetrators mentioned were strangers, and known community members, respectively. Similarly, respondents who reported attempted forced sex identified the most common perpetrators as intimate partners, followed by community members and strangers.

Of the women who reported being touched against their will, the mean age was 21 years. Known community members were the main perpetrators, followed by intimate partners and strangers. For coercive experiences, the mean age ranged from 20.9 to 24.3.

Table 6 Reported perpetrators by relationship to the respondent and type of sexual assault

Perpetrator	*Forced Sex (N=233)* %	*Attempted Forced Sex (N=136)* %	*Touched against her will (N=308)* %
Intimate partner	73.8	47.1	33.7
Known community member*	10.3	30.9	45.3
Stranger(s)	12.0	18.4	18.0
Family member	3.9	3.7	2.9

* Includes perpetrators know to the respondent such as teacher, schoolmate, neighbor or colleagues at work.

Association between demographics and sexual assault

One goal of the study was to gain a better understanding of those who experienced forced sex. Of the socio-economic and demographic characteristics investigated, the following were associated with experiencing forced sex: highest grade completed, marital/relationship status, ownership of luxury items, structure of the home, mother still alive, age when mother died, and father still alive. Respondents with higher socioeconomic status, measured in this study by possession of a phone and/or car, were less likely to have experienced forced sex. As educational level increased, the likelihood of having experienced forced sex decreased. This finding may be the result of lower incidence among respondents with higher socioeconomic status or may reflect reluctance of respondents with higher socioeconomic status to report forced sex to interviewers.

Table 7 Associations between select sociodemographic characteristics of respondents and history of forces

	% Experienced Forced Sex	p-value
Age categories		.410
18-25	21.7	
26-35	23.8	
Childhood residence (to age 15)		.784
City	20.1	
Town	22.9	
Rural/farm	22.8	
Religion		.046
Catholic	22.2	
Protestant	19.3	
Zionist/Pentecostal/Other	28.1	
Education		.002
Std 1-7 or no education	26.9	
Form A – C	21.4	
Form D and beyond	14.4	
Marital/relationship status		.005
Married/cohabitating	19.0	
Single	22.8	
Separated/divorced/widowed	28.6	
Boyfriend(s)	36.8	
Currently employed	22.7	.874
Type of employment		.396
Factory worker	21.2	
Domestic worker	31.0	
Street vendor/hawker/casual	20.9	
Other*	20.3	
Number of rooms in house		.109
One	24.9	
Two-three rooms	18.8	
Four or more	22.4	
Number of persons in house		.004
Less than four	21.4	
Four to six	20.7	
More than six	34.8	
House building materials		.002
Cement brick	20.9	
Mud	28.1	
Other	34.2	
Has car &/or phone	17.9	.022
Mother not living	28.7	.025
Age when mother died		.022
Less than or equal to14 years	38.4	
More than 14 years	22.8	
Father not living	24.0	.017
Age when father died		.756
Less than or equal to 14 years	23.9	
More than 14 years	25.2	

* Includes civil servant, shop worker, salon/hair dresser and sex worker

Results

Respondents with mothers and/or fathers no longer living were more likely to have a history of forced sex. Moreover, women who lost their mothers at an earlier age (less than 14 years) were more likely to have experienced forced sex.

Higher education (.002), less crowded living arrangements (.004), and being married/cohabiting (.005) were associated with lower levels of forced sex.

3.4 Cultural context of sexual violence

Defining sexual violence

Respondents were asked how sexual violence is defined and perceived, particularly whether forced sex is defined as rape.

Nearly 95% of survey respondents reported that to them 'forced sex' and 'rape' are the same thing. However, approximately 30.5% believed a boyfriend or husband could not rape, but could only "force sex". FGDs provided further insight into the situations when forced sex is not perceived as rape. The perceived severity of the assault seems to vary based on whether the perpetrator was known to the woman and whether or not the woman was a virgin, as reflected by the following comments:

> He (husband) forces her but it is said that it is not rape. It is just a violation.

> Rape is when one is forced to have sex against one's will. This is different when the person concerned is the husband. The husband has paid lobola implying that he has 'bought his wife.' This gives him the right to sex whenever it pleases him, then it's not rape.

Lobola is a traditional bridewealth payment made by the groom to the bride's family. Although one respondent attributed a husband's right to sex to this tradition, focus group participants reported that this right applies to husbands in general. One respondent noted that if a wife (of any marriage type) denies her husband sex:

> He would take the woman to the chief's place where the woman would be reminded that she has to satisfy her man's needs.

Some participants criticized women who refused to satisfy their husband's right to sex:

> It is a very bad thing for a woman to deny her husband sex. It is a woman's duty to provide sexual services to her husbandregardless of whether she feels like it or not.

The statement of one participant gives an idea of perceptions of sexual assault perpetrated by a boyfriend:

> Once my boyfriend raped me. I had refused to have sex with him, but he forced himself on me. You see people think because he was my boyfriend I had wanted to have it.

The age of the woman also seems to be a factor in the community's perception of the severity of the assault, as demonstrated by the statements of focus group participants:

> When a woman has been raped they (the community) say how can such an old person allege to have been raped? She was not raped; she is already exposed to sex.
>
> People say that an older person can never be raped; the only person that can be raped is someone who has not had sex before. Most people think that a married woman can't be raped, whether by a stranger or by her husband.

While attempting to solicit information on forced sex and reporting patterns of younger versus older women, interview and focus group participants frequently indicated that a woman already exposed to sex could not be raped. This item was subsequently added to the attitudinal section of the questionnaire, and 23% of the respondents agreed with the statement: "Some women are forced to have sex, but rape can only happen to virgins."

Although this perception was not universal, when the possibility of rape was acknowledged, participants consistently affirmed that forced sex was worse for virgins, as noted by the following statements:

> As young girls, their bodies were not ready for sex.
>
> An experienced woman has already traveled that road.

Even though, many respondents felt that rape could only happen to virgins, there were circumstances noted in which forced sex with a virgin was not considered rape. For example, if the perpetrator was a boyfriend or if the woman was over the age of 18.

Perceived causes of sexual violence

Causes of sexual violence were further explored through both quantitative and qualitative components of the study. The majority of respondents reported that men rape for sexual pleasure (See Table 8). This response was reinforced by qualitative research, where a common belief was that sexual lust was an innate quality of 'healthy men,' as noted in the following statements:

> It is commonly said that a man's sexual desires emanate from women. It is also said that when a man is hospitalized, in order to establish whether he is really fine, female nurses would tease him, then if his male organ responds, he is fine."
>
> It is true that a man's sexual desire is derived from women, because if a man is walking behind a woman, all he ever thinks of is sex, if he is healthy.

Most informants stated that not all men were prone to sexual violence. Men who did not assault women were perceived as having 'control' over their desires and/or were able to successfully negotiate sex with women. (Data not shown)

Table 8 Distribution of respondents' opinions as to why some men sexually assault women (N=1049)

	%
For sexual pleasure	41.1
Don't know	12.2
To have power over women/hate women	10.6
Other*	9.0
Men are violent by nature	7.8
Mental illness	7.7
Bad behavior/attitude	7.7
HIV+ men don't want to die alone	2.2
To cure HIV/AIDS	1.7
Total	*100*

* includes alcohol/drug use, mistreatment as children, afraid of love, perception of owning the female or lobola, lack ofself-control, evil spirits, men are silly and others

Although less than 1% of survey respondents mentioned alcohol as a primary reason why men assault women, informants in the qualitative study frequently mentioned alcohol in connection with sexual violence. Alcohol was described as both a cause, as it loosens men's inhibitions, and an excuse for sexual violence. One informant stated that:

> Men hide behind alcohol so they can do their evil deeds.

Women who consumed alcohol were blamed for being sexually violated since being drunk made them exhibit 'unbecoming' behaviors. In addition to 'asking for it,' some informants stated that a drunk woman would not even mind being assaulted.

A woman's behavior was also cited during qualitative research for why women are assaulted:

> Sometimes it is us girls who bring it onto ourselves by wearing short enticing clothing.

Other informants noted that walking alone at night resulted in men not being able to control their sexual feelings and blamed such women as being irresponsible.

HIV status was another cited reason why men assault women. The following comments illustrate this perception:

> They want to spread the virus, they don't want to die alone.
>
> Sometimes (men assault women) because they know they are infected with HIV/AIDS. They would want to spread it as much as possible since they believe they were infected by a woman, therefore they want to give it back to women.
>
> An HIV positive man has sex with a virgin and the virus would leave his body. He would also be cured of other sexually transmitted diseases" and "Some HIV positive rapists believe that by raping, the virus would leave their body and enter that person's body so they will be cured.

The 'cleansing myth' has been documented in other studies in Southern Africa. Ten percent of survey respondents either agreed or were unsure that having sex with a virgin could cure AIDS, and 1.9 % believed this to be a reason why men assaulted women. (Data not shown.) In addition, some women reported that the power to cure HIV extended beyond virgins to include sex with elderly women who were no longer sexually active, women who had just given birth and 'well-behaved women.'

The narrow local definition of rape, as well as expectations of sexual rights in marriage and the sexual rights of women in Lesotho generally, appears to excuse and condone sexual violence in the study sites. As part of the qualitative component, a list of statements was developed to explore these concerns. Respondents were asked whether they agreed, disagreed or did not know whether a statement was widely held in their community.

Results

More than 50% of respondents agreed with three of the six negative attitudes/myths pertaining to marriage, women and sex as shown in Table 9. However the majority of women also affirmed all three positive attitude statements.

Table 9 Women who agreed with select attitudes and myths pertaining to women, marriage and sex. (N=1049)

Negative attitudes/myths	*% Agreed*
Family problems should only be discussed with people in the family	85.9
A woman needs her husbands permission to do paid work	64.3
If a man has paid lobola for his wife, he owns her	63.4
A good wife obeys her husband even if she disagrees	63.2
If a woman works she should give her money to her husband	52.1
A man should have the final say in all family matters	50.6
Children belong to a man and his family	45.5
If a drunk woman is raped, it is her own fault	44.1
If a man has paid lobola for his wife, she must have sex when he wants it	43.9
There is nothing a woman can do if her husband wants to have girlfriends	39.9
It's a wife's obligation to have sex with her husband even if she doesn't like it	39.0
A man cannot rape a commercial sex worker	36.6
It is important for a man to show his wife/partner who is the boss	36.2
If a husband forces his wife to have sex, this cannot be considered as rape	36.0
Some women are forced to have sex, but rape can only happen to virgins	22.7
Positive attitudes/myths	
Men should share the work around the house with women such as doing dishes, cleaning and cooking	84.7
If a man mistreats his wife, others outside of the family should intervene	73.8
A woman should be able to choose her own friends even if her husband disapproves	56.8

Survey respondents' perceptions regarding a woman's ability to refuse sex are reported in Table 10. For all situations, less than half of respondents felt a woman could refuse sex. Over a third of the respondents (37%) said that a man could not rape a commercial sex worker (CSW), given the narrow local definition of rape (data not shown).

Table 10 Respondents who agreed that a woman can refuse sex with her husband in select situation. (N=1049)

Agreed a married women can refuse to have sex with her husband if:	%
She doesn't want to	36.9
He is drunk	29.8
She is sick	8.7
He mistreats her	16.8

Perceptions of sexual violence and their influence on disclosure

The majority of women who experienced forced sex (68.9%), told someone of the experience. However only 29.7% sought medical treatment and 17.8% reported the event to the police. Among those who did disclose, the majority confided in a female friend (49.9%). The next most common confidants were mother, sister and healthcare provider (37.2%, 21.3% and 21.3%), respectively. (Data not shown)

Table 11 shows that the pattern of disclosure, reporting and health care seeking differs by perpetrator. Women who were forced to have sex with an intimate partner were significantly less likely to disclose, seek medical care or report the event to the police as compared to those who had been forced by a stranger, family member or a known community member (i.e., neighbor, teacher) (p=.000).

Table11 Women who sought medical care, reported to police, or ever told anyone after experiencing forced sex by relationship to the perpetrator. (N=1049)

Perpetrator	*Sought medical care*	*Reported to police*	*Ever told someone*
Intimate partner	18.6	4.1	64.3
Known community member*	52.2	65.2	87.0
Stranger(s)	75.0	53.6	82.1
Family member	55.6	17.8	100
Total	*29.7* *p=.000*	*17.8* *P=.000*	*68.9* *p=.000*

*Includes perpetrators know to the respondent such as teacher, schoolmate, neighbor or colleagues at work.

The age of the respondent was associated with health care (p = .030). Approximately 43% of the respondents who experienced forced sex at age 16 and under, reported seeking medical treatment as compared to only 27.1% of women aged 17 years and above (Data not shown). The reluctance of woman 17 above to seek healthcare may be related to the local definition of rape, since an 'experienced' woman cannot be raped.

The reasons for not seeking medical treatment, not reporting to the police and not telling anyone are presented in Table 12.

Table 12 Distribution of reasons for not seeking medical treatment, not reporting to the police and non-disclosure after experiencing forced sex.

Reason	*Not seeking medical treatment(N=201)*	*Not reporting to the police(N=163)*	*Not telling anyone (N=70)*
	%	*%*	*%*
Perceive experience as normal/ not serious	22.1	10.0	8.6
Fear of bringing bad name to self/family	20.9	21.9	35.7
She loved him	17.2	22.9	18.6
Don't know/no answer	13.5	8.5	1.4
Afraid would not be believed	8.6	10.4	14.3
Embarrassed/ashamed	4.9	4.5	11.4
Afraid would end relationship	3.1	6.0	4.3
Fear of threats/consequences/ more violence	1.2	4.5	2.9
Believed not help/know other women not helped	-	3.0	2.9
Other*	*8.6*	*6.5*	**-**

* Other reasons included, "because my children would starve," "did not have the money," "the police station was too far," and "thought her parents would report it." Note: Only first response was recorded.

Of those survey respondents who did not seek medical treatment, the most commonly mentioned explanations were that the assault was normal/not serious, fear that it would bring a bad name to self/family and being in love with the perpetrator, respectively. The two most common cited reasons for not disclosing an incident to the police was loving the perpetrator (22.9%) and fear of bringing a bad name to self or family (21.9%). The majority of survey respondents who did not disclose their experience of forced sex to anyone stated fear of dishonoring herself or her family as the primary reason for nondisclosure (35.7%).

Familial and public response to the disclosure of sexual assault

The following statements from focus group participants highlight how public reaction can vary depending upon the perceived culpability of the woman:

> If you were seen with your abuser earlier, say at some public bar, then later you claim he raped you, they (the community) do not consider it a serious case.

> People would say no wonder she has been raped, she drinks too much and she walks around at night.
>
> In the case of young girls, sometimes people accept that she was raped or they say it is because she is all over the place. If she is raped on her way home from school they say she brought it onto herself by the way she was dressed…

Based on findings from qualitative research, it appears that families are just as likely as communities to blame a female family member for being sexually assaulted. One respondent recalled a story about witnessing a friend's assault

> I ran to her home to notify her brother, who refused to rescue her saying he had often told her not to go about at night.

Another respondent spoke of the accusatory reaction of her friend's mother when hearing of her daughter's assault:

> When she told her mother, instead of being sympathetic she cursed her and blamed her for moving about during the night.

Respondents recalled incidents, usually during an argument, when husbands, fathers or siblings harshly reminded women of a sexual assault incident. Not all focus group participants agreed that families tend to blame the woman, however. One participant stated that it was common for male family members to become very angry and seek retribution if a female relative had been sexually attacked. However, this reaction was dependent upon the circumstance and the woman's perceived responsibility. The range of family responses to sexual assault may explain why so few respondents confided their forced sexual experience to their fathers (12.8%) and brothers (9.8%). (Data not shown)

Qualitative data suggest that participants often spoke of the community's disparaging reaction once it was learned that someone has been "raped." Even when it was clear to the community that the woman "did not bring it upon herself," (i.e., legitimately raped based on the local definition) she was labeled, "*as the one who was raped*." Respondents stated that communities often gossiped about a woman who had been raped, debating whether she was HIV positive and the impact the rape would have

on her present or prospective marital status. Some respondents mentioned that an incident of rape could become *"a laughing matter within the community."* Below, are two examples of the scorn inflicted upon women who reported experiencing rape:

> They badmouth her. They look down upon her and treat her like she is dirty and like she is ill mannered and worse than everybody.
>
> People will say they have low morals, a prostitute, even though you may be a married woman with children, just because you were sexually abused.

3.5 Associations of experienced sexual violence and high risk sexual behaviors

Previous research has documented an association between having experienced sexual assault and engaging in risky sexual behaviors. The behaviors examined in the present study included condom usage, age of first pregnancy, number of partners in the last twelve months and coercive experiences.

Condom use

Respondents were asked whether they had used a condom during last sex and whether they had used a condom in the past 30 days. There was no significant difference among respondents who had and had not experienced sexual violence with regard to either of these variables, even when categories were collapsed into never and ever having used a condom. (Data not shown)

Age of first pregnancy

Experiences of forced sex were significantly associated with the age of first pregnancy. Among women who had experienced forced sex, the mean age for first pregnancy was 18.9 years, compared to 19.8 for those who had never been forced to have sex ($p = .000$). The mean age of first pregnancy was 19.6 for the whole sample.

Number of sexual partners in the last year

The number of sexual partners a respondent had in the last year was significantly different among those who had and had not experienced sexual violence. This difference was significant for both forced and coercive sex. Although having one partner was the most common response among all respondents, the percentages were considerably lower among those who had experienced sexual assault compared to those who had not. The percentage of respondents reporting two and three or more partners in the past year was higher for those who experienced sexual assault, regardless of the type of assault (see Table 13).

The qualitative data suggest that many women felt a history of forced sex would make women more likely to avoid relationships with men. This view is highlighted by the following responses from focus group participants:

> She changes (after rape) in that sometimes she would think that she doesn't have to go on living and she no longer has sexual relations with men because they would be bringing more problems on to themselves.
>
> It took me many years to start having a relationship with boys because I was afraid of them.

Table 13 Distribution of reported number of sexual partners in previous 12 months by type of sexual violence experience. (N=939)

	Number of sexual partners			
*Type of sexual violence**	*0*	*1*	*2*	*3 or more*
Forced sex (N=236)	6.8	55.1	22.3	14.8
Sex for fear of losing money/gifts (N=83)	1.2	49.4	27.7	21.7
Sex for wanting money/gifts (N=94)	2.1	37.2	31.9	28.7
Sex with a man who provided transport (N=19)**	5.3	26.3	26.3	42.1
Sex with a man threatening to end relationship (N=41)	2.4	56.1	22.0	19.5
Sex pressured by arguments (N=187)	3.2	62.0	18.7	16.0
Sex due to fear of violence or other (N=215)	5.1	52.1	27.4	15.3
Sex because of being to drunk to stop him (N=17)	-	23.5	47.1	29.4

* p-value=.000 for all types of sexual violence except "Sex with a man who provided transport"

** p-value=.047

Coercive Experiences

Table 14 indicates that a history of forced sex is associated with six of the seven coercive experiences listed. Participants who had experienced forced sex, were more likely than women who had not to engage in sex for fear of losing money/gifts, wanting money/gifts, in exchange for transport, due to fear and due to being drunk. The only coercive experience that was not significantly associated with forced sex is sex with a man threatening to end the relationship.

Table 14. Respondents who have experienced forced sex by coercive experience. (N=236)

Coercive Experience	*%*	*p-value*
Sex with a man who provided transport	68.4	.000
Sex because of being drunk to stop him	58.8	.000
Sex because of fear of violence or other	55.3	.000
Sex for fear of losing money/gifts	44.6	.000
Sex because of wanting money or gifts	43.6	.000
Sex pressured by arguments	43.3	.000
Sex with a man threatening to end a relationship	22.6	NS

Whether or not forced sex is a risk factor for coercive experiences or vise versa cannot be determined from this study. However, these data do suggest that they are associated. The relationship between forced sex and coercion remained significant when all seven coercive experiences were combined. That is, 66.9% of women who had experienced forced sex had also experienced one or more types of coercion (p =.000).

3.6 Exposure to community interventions

Response of the judicial system

Findings reported in this study suggest that fear of dishonoring name and family, love for the perpetrator, and fear of not being believed were important reasons for not reporting forced sex to the police. Qualitative data provided additional reasons why women might fail to report sexual assault, including the financial cost of reporting and inappropriate treatment by police officers towards women who report sexual assault.

Some informants reported that fear of embarrassing questions asked by police was the main reason for not reporting a sexual assault. They explained that officers were likely to ask whether the woman cried, felt pain or enjoyed the experience. It was also reported that officers asked questions in a manner that implied blame, such as why she was out of her home at night. In addition, informants described their fear of having to publicly disclose explicit details of an assault to a group of male police officers at the front desk without privacy. One focus group participant provided an example:

> Some cases are reported, but even with those that are, people find themselves withdrawing charges in an effort to avoid vulgar questions by the police and the courts of laws. Sometimes women are asked whether they did not enjoy the ordeal. If this actually happened to me, I would feel embarrassed knowing what happened to me and weigh it against the type of questions that the police would be asking and would opt for not reporting.

Another barrier cited to reporting an assault was the laborious reporting procedure required. A woman must first report the assault to the police, and obtain a form that must be taken to a medical practitioner. Following a medical examination to certify that she has indeed been sexually assaulted, the certified form must be returned to the police. The reporting process includes financial costs, as the woman must pay for the medical services received.

Some focus group participants complained about the transportation and medical costs involved in reporting a sexual assault. Informants were also concerned that it would be difficult to prove to police officers that sexual assault had occurred, if the medical exam showed no evidence (i.e., battered body, semen present). Furthermore, if a woman did not report the assault immediately or had bathed before reporting it, police were more likely to treat her complaint with skepticism. Although many women complained about the difficulties of reporting sexual assault, many informants stated that they did not know where to report sexual assault. One respondent, whose daughter had been raped twice, admitted that she wanted to report the incidents but did not know where to go or what to do.

Only 11% of respondents who had experienced forced sex or attempted forced sex reported the incident to the police. These women reported inconsistent treatment by the judicial system. Satisfaction with the legal system also varied considerably. Only 37.5% were satisfied with the police system after reporting the event. (Data not shown.)

Although 90% of respondents who had experienced forced sex or attempted forced sex indicated that they had wanted to take action against their perpetrator, only 35% were advised to do so by the police. Of women who filed charges, thirty-five percent of them withdrew the charges, and less than half of the remaining cases ever went to trial. Some participants explained that prosecuting someone for sexual assault takes so long that many woman inevitably stop pursuing the indictment. Nevertheless, all cases tried resulted in conviction of the perpetrator. Interestingly, of the 14 cases that did go to trial, all of them (100%) were successful in convicting the perpetrator. (Data not shown)

Despite differing perceptions about the way police handled cases of attempted and actual sexual assault, 72.5% of the 40 cases that reported an assault felt that the law could help prevent/stop sexual violence.

Respondent's suggestions for helping survivors of sexual violence

> "Women want to see sexual abuse to women and children come to an end."

When asked whether they felt that women who had experienced forced sex and/or rape needed some type of support, 94.9% of respondents responded affirmatively. Table 15 details the types of services recommend by respondents to assist women who have experienced sexual violence.

Table 15 Services suggested to help women who experienced sexual violence. (N=1049)

Type of service suggested (Multiple responses allowed)	*%*
Medical treatment/tests/medication	54.9
Counseling	29.1
Severe punishment for perpetrators	16.2
Support from friend/community/relatives	6.1
Better treatment from the police	1.3
Don't know	1.1
Traditional justice system	0.3
Women should protect themselves	0.2
Other	21.7

Based on both survey results (54.9%) and qualitative investigation, researchers found that the most common type of help suggested was assistance with the costs incurred for the medical examination and medicines. Respondents also suggested that follow-up HIV and STD tests would be most helpful, as well as a hospital escort to help ease discomfort.

The second most common suggestion (29.1%) was counseling. Individual and support group counseling were recommended to help the woman deal with issues such as fear of men and isolation.

16.2% of the respondents stated that it would be helpful if perpetrators received appropriate punishment. Punishments recommended by respondents included prison sentences (62.3%), public lashings (13.6%) and death (11.7%). (Data not shown)

Qualitative data indicates a suggestion for awareness raising and education. One woman who experienced a brutal sexual attack by a stranger stated:

> …public assemblies for women, where women will be taught how they should react when something like that happens to them are needed.

Respondents suggested that information about sexual assault services could be distributed at funerals, wood and water gatherings, clinics, hair dressing salons, and lines outside factories where they wait for employment.

Exposure to SHARP!

When survey respondents were asked about their familiarity with SHARP!, only 11.5% reported having heard of SHARP!. A significantly higher proportion ($p<0.000$) of women in program areas (17.9%) had heard of SHARP! compared to those in non-program areas (5.4%).

Comments on the SHARP! Program

I like their training sessions, more than anything else.

We know that if we are sexually abused SHARP! can help us get to the clinic.

SHARP! enlightens and gives advice to families that are affected by AIDS, it also gives advice to neighbors who are old and not satisfied with their situation

I like SHARP! because it provides free condoms, especially to people who do not have easy access to them.

SHARP! aims at providing women with information that helps protect them from HIV/AIDS. They also request us to give information on their operations to others women who are not aware of their activities. It teaches us ways in which we can protect ourselves from sexual abuse, even those that take alcohol.

Results

Survey respondents who reported having heard of SHARP! were asked about their understanding of SHARP! activities. (See Table 16.) Approximately 42% of all respondents stated that SHARP! provides HIV/AIDS education only. With regard to SHARP! activities in the area of sexual violence, 15.2% of the respondents from program areas reported awareness of these efforts, versus 13.8% from non-program areas. SHARP!'s endeavors in both HIV/AIDS education and SVAW were known to 16.3% of program area respondents and 6.9% of non-program respondents. Fourteen percent of program area participants who reported having heard of SHARP! did not know what the program did.

Among those familiar with SHARP!, a higher proportion (94.6%) of women in program sites than in non-program sites (79.3%) reported having seen SHARP! materials ($p<0.013$). Yet, there are no significant differences between the two areas on any of the other program activities. A larger percentage of respondents in program areas had attended educational sessions by SHARP! than those in non-program areas.(27% and 20.7% respectively) Interestingly, a greater percentage of respondents in non-program areas reported having spoken to a SHARP! PE compared with women in program areas (37.7% and 34.8% respectively). (Data not shown.)

Once the program was explained to the study participants, 85.1% felt that it could be helpful in preventing violence against women. The following sections provide the impact results.

Table 16 Comparison of spontaneous descriptions of SHARP! activities among those familiar with SHARP! by residence.*

Description of SHARP! activities	*Program areas(N=92)*	*Non-program areas(N=29)*	*Total(N=121)*
	%	*%*	*%*
HIV/AIDS education	42.4	41.4	42.1
Teaches women to protect themselves/works on issues concerning sexual violence	15.2	13.8	14.9
HIV/AIDS education & teaching women to protect themselves/SVAW	16.3	6.9	14.0
Other	12.0	17.2	13.2
Don't know	14.1	20.4	15.7

*p-value > .05 for all descriptions, no statistically significant difference among areas.

3.7 Differences in the level of sexual violence and related attitudes in program and non-program areas.

Sexual violence

Quantitative data indicate similar incidence rates of sexual violence in the program and non-program areas, 50.2% and 49.8% respectively (p=.348).

Sexual coercion

The findings listed in Table 17 demonstrate that significantly more women in program areas than in non-program areas reported having consented to sex due to pressure (20.2% versus 15.5%) and fear (24.1% versus 17%). There was no significant difference between the two areas with regard to other types of sexual assault identified in this study.

Table 17 Comparison of reported sexual coercion experience in program and non-program areas.

	Program areas (N=514)%	*Non-program areas(N=535)%*	*p value*
Ever experienced any type of sexual coercion	43.6	47.3	.047
Type of sexual coercion experience			
Sex for fear of losing money/gifts	8.9	6.9	NS
Sex because of wanting money/gifts	9.5	8.4	NS
Sex with a man who provided transport	1.9	1.7	NS
Sex with man threatening to end relationship	4.7	3.2	NS
Sex pressured by arguments	20.2	15.5	.046
Sex because of fear of violence or other	24.1	17.0	.004
Sex because of being too drunk to stop him	1.6	1.7	NS
Ever had sex when she didn't want to	5.8	3.9	NS
Employer insisted sex prior to employment*	6.5	5.1	NS
Sex with man threatening to cease her employment**	2.6	3.9	NS
Sex with teacher who threatened bad results	1.9	3.4	NS

* Excludes 69 respondents who had never tried to obtain employment.

** Exludes 125 respondents who had never been employed.

Sexual assault

Women in program areas reported significantly more forced sex in their lifetime than in non-program areas (p=.048). (See Table 18) Boyfriends (former or current), followed by strangers and neighbors were the primary perpetrators in both areas. Fewer participants in program areas (86%) than non-program areas (95%), described their experience as rape (p = .017). However, further analysis revealed that slightly more program area than non-program area respondents (77% and 70.1% respectively) had been forced to have sex by a boyfriend or husband, although this finding was not significant. (Data not shown)

Program area respondents (8.6%) were more likely to have been forced to do something sexually that they considered degrading or humiliating (5.4% in non-program areas, p = .05). A similar percentage of women from program and non-program areas reported an experience of forced sex within the last year (17.2% and 15%, respectively). Also, within the last year, 27.5% of program area participants and 26.9% of non-program area participants had experienced attempted forced sex. (Data not shown)

Table 18 Comparison of reported sexual assault experiences in program and non-program areas.

	Program areas (N=514)%	*Non-program areas(N=535)%*	*p value*
Ever experienced any type of assualt	51.8	48.4	.279
Type of sexual assault experience			
Ever experienced forced sex	25.1	20.0	.048
Ever touched against her will	28.8	29.9	NS
Ever forced to touch man's private parts	9.1	10.8	NS
Ever forced to do any other sexually degrading activity	8.6	5.4	.050
Ever experienced attempted forced	13.4	12.5	NS

Respondents who reported attempted forced sex were asked how they reacted. A significantly higher proportion of program area participants ran away (p =.045) from the perpetrator, whereas a higher proportion of non-program area participants fought back (p=.002). (See Table 19).

Table 19 Comparison of responses to attempted forced sex by program and non-program areas.

Response	Program areas (N=69) %	Non-program areas (N=67) %	Total (N=136) %	p value
Screamed	29.0	44.8	36.8	NS
Ran away	44.9	28.4	36.8	.045
Fought back	23.2	49.3	36.0	.002
Threatened him	23.2	17.9	20.6	NS
Did nothing	15.9	6.0	11.0	NS
Other	4.3	-	2.2	NS

There were no significant differences between program and non-program areas in terms of awareness of sisters' forced sex or rape experiences. However, a higher proportion of women (41.9%) in non-program areas than in program areas (34.6%) reported knowing someone in the community who has been raped ($p<0.016$). There were no significant differences among the two areas regarding reporting sexual assault to the police, seeking medical treatment, and/or telling someone/no one about the event. However, more respondents from program areas (16.7%) sought legal services than in non-program areas (5.8%), ($p=.03$). (Data not shown)

Attitudes, myths and sexual violence

In section 3.5, we found an association between attitudes towards rape and the cultural expectations of wives and women and sexual violence (refer to Table 9 for list of attitudes/myths). In this section, we explore differences by program and non-program areas.

No significant differences between respondents in the two areas were found, with the exception of one variable: If a woman works she should give her money to her husband. In this case, it was demonstrated that a higher percentage of women (53.9%) in program areas agreed with this statement as compared to only 50.5% in non-program area ($p = .042$).

Responses were compared from both areas to questions about situations when a woman can refuse to have sex with her husband and circumstances when physical abuse by a husband is justified (refer to Table 10 for description of circumstances). There were no significant differences among responses from program and non-program areas for any of the variables. (Data not shown.)

3.8 Differences in STD/HIV knowledge and behavior in program and non-program areas

STD Knowledge

Respondents from both areas had similar knowledge of diseases transmitted through sexual intercourse. Those who reported being aware of STDs were asked to list STD symptoms. Genital ulcers/sores was the most commonly mentioned symptom by women in both areas, but was more frequently reported by women in program areas ($p = .008$) (see Table 20). Other commonly mentioned symptoms included foul smelling discharge and genital discharge. About 3% mentioned other symptoms not listed in the questionnaire, and these included AIDS, pubic lice and sores on the body.

Table 20 Comparison of spontaneously mentioned symptoms of STDs by program and non-program areas.

Symptom	*Program areas (N=445)*	*Non-program areas (N=447)*	*Total (N=892)*	*p value*
	%	*%*	*%*	
Genital ulcers/sores	59.6	50.8	55.2	0.008
Foul smelling discharge	33.0	36.5	34.8	NS
Genital discharge	24.7	27.1	25.9	NS
Itching	24.3	27.3	25.8	NS
Burning pain on urination	19.1	21.7	20.4	NS
Abdominal pain	16.2	14.3	15.2	NS
Swelling in groin area	11.2	10.1	10.7	NS
Other	3.8	2.7	3.3	NS

HIV Knowledge

To measure HIV knowledge, participants were asked about prevention methods, AIDS myths, and facts relating to mother-to-child transmission. These variables, measured individually and as three composite indicators, included the following dimensions: 1) "Knowledge of prevention methods" included awareness of the three most common HIV prevention methods (i.e., abstinence, being faithful to one uninfected partner, and condom use); 2) "No Incorrect Beliefs about AIDS" explored common misconceptions about HIV transmission and cures with four items (i.e., can get AIDS from mosquito bites, sex with a virgin can cure AIDS, etc.); and, 3) "Mother-to-Child Transmission (MTCT)" included two items, transmission through breastfeeding and during pregnancy. To achieve a pass on any composite indicator, the respondent had to correctly answer all of the items within that category (see Table 21).

Table 21 HIV/AIDS Knowledge and beliefs by program and non-program area.

	Program areas (N=514)	*Non-program areas (N=535)*	*Total (N=1049)*	*p value*
	%	%	%	
Knowledge of HIV Prevention Methods	*60.9*	*66.5*	*63.8*	*NS*
People can protect themselves by having one uninfected faithful partner	87.5	89.9	88.9	NS
People can protect themselves by using a condom correctly at all times	91.1	90.7	90.8	NS
People can protect themselves by abstaining from/not having sexual intercourse	71.8	74.0	72.9	NS
No Incorrect Beliefs about AIDS	*33.3*	*32.5*	*32.9*	*NS*
People can bewitch someone else so that they have AIDS symptoms (No)	92.6	93.8	93.2	NS
Having sex with a virgin can cure AIDS (No)	90.7	89.9	90.3	NS
People can get the AIDS virus from mosquito bites (No)	55.6	60.4	58.1	NS
Healthy looking people can spread HIV (Yes)	68.9	65.2	67.0	NS
Mother to Child Transmission	57.8	63.2	60.5	NS
An HIV woman can transmit virus to unborn child (Yes)	91.8	93.3	92.6	NS
An HIV mother can transmit virus to her new born baby through breastfeeding (Yes)	60.5	66.4	63.5	.049

There were no significant differences between program and non-program areas for the three composite indicators measured. Among all respondents, knowledge of all three indicators of HIV/AIDS prevention was 63.8%. Most women in both areas knew that people could be protected from HIV by using a condom correctly at every sexual encounter and by having one uninfected faithful partner. Slightly less than three-quarters of women in both program and non-program areas agreed that abstinence could protect them from HIV.

More than 70% of the sample had one or more incorrect belief(s) about HIV/AIDS. The majority of women disagreed that people could be bewitched to have AIDS symptoms (93.2%) and that having sex with a virgin could cure AIDS (90.3%). However, only 55.6% of women in program areas and 60.4% in non-program areas were aware that people could not get AIDS from mosquito bites. Only 68.9% of respondents in program areas and 65.2% in non-program areas agreed that a healthy looking person could spread HIV.

Sixty-three percent of women in non-program areas and 57.8% in program areas were aware of both mechanisms of MTCT. However, the majority of women in both areas knew that an HIV positive woman could transmit the virus to her unborn child. A much smaller percentage of women were aware of the MTCT risk through breastfeeding. Interestingly, women in the program area had significantly less knowledge of this risk factor than women from non-program areas ($p = .049$).

Sexual activity

The following two indicators were selected to measure potentially risky sexual behavior: 1) whether the respondent had ever engaged in sex and, if so, 2) the number of sexual partners within the last 12 months. There was no significant difference between women who reported never having sexual intercourse in program and non-program areas (11% and 9.8%, respectively). For those who reported having sexual intercourse, the mean age at first sex was 17.8 years in both program and non-program areas. Sexual initiation occurred most commonly at age 18 in both areas.

The number of partners in the last 12 months ranged from 0 to 20, with only five respondents reporting five or more partners. However, the majority of women in both program and non-program areas reported only one sexual partner in the last year, (66.7% and 71.2% respectively, a non-significant difference). Although this research has provided information on women's sexual behavior, the behavior of their partners still remains unknown.

Condom use

Approximately one-third of all respondents reported using a condom the last time they had sex. When asked who made the decision to use a condom, 37% of women in program areas and 33.3% in non-program areas indicated that they made the decision to use a condom. Forty one percent of respondents in program areas and 34% in non-program areas reported that both partners made the decision to use a condom. Roughly 22% of respondents in program areas and 32.7% in non-program areas said that their partners decided to use a condom. No significant difference was found between the two areas for any of these variables.

The majority of women in both program (41.8%) and non-program areas (49.4%) reported never having used a condom with their partner(s) in the last 30 days. Yet, 19.9% of program area participants and 16% of non-program areas participants reported having always used a condom during sex in the past 30 days. No significant difference was found between the two areas when analyzing this variable with the five possible levels - always, usually, sometimes, rarely and never. However, when limiting it to a binary variable as to whether they had ever or never used a condom in the last 30 days, a significantly higher proportion of program area respondents used a condom ($p= .02$) (see Table 22).

Table 22 Comparison of frequency of condom use in previous thirty days program and non-program areas.

Frequency of use	*Program areas (N=514) %*	*Non-program areas (N=535)%*	*Total (N=1049)%*
Always	19.9	16.0	17.9
Usually	7.7	7.5	7.6
Sometimes	20.4	16.0	18.1
Rarely	10.2	11.2	10.8
Never	41.8	49.4	45.7

Note: p=NS. As a binary variable "ever used/never used a condom" p=.020.

Self-efficacy is viewed as an important precursor to condom usage. In order to determine respondent's self-efficacy for negotiating condom use in this study, respondents were asked how confident they felt (ranging from very, fairly or not) in convincing their current or most recent partner to use a condom. Similar proportions of women from program (41%) and non-program (37%) areas felt "very" confident that they could convince their current or most recent sexual partner to use a condom. Nearly 28% from program and 25% from non-program areas felt "fairly" confident. The remaining 31.3% from program and 37.8% from non-program areas indicated that they were not at all confident that they could convince their partner to use a condom. When considering self-efficacy as a three-level variable, the difference was not significant. However, when analyzing whether women were or were not confident about convincing their current or more recent boyfriend to use a condom (combining 'very' and 'fairly' and comparing it to 'never'), it was evident that more program area participants were confident than non-program participants (p = .037).

Another method used to approximate self-efficacy was to assess whether respondents had ever discussed the topic of condoms with a recent or current sexual partner. There was no significant difference between program area and no-program area respondents with regard to this variable, and responses were similar (68.9% and 63% respectively). One SHARP! participant explained her condom negotiation tactics below:

I tell my husband that given these new sexually transmitted diseases that are prevalent we can no longer trust each other. I tell him that even though we are married to each other the level of trust is so low, especially since he works in the mines in South Africa. I ask him to use a condom, and then his argument is we need to have a child. In return I would tell him that we have to get tested for HIV/AIDS before we even think of having a child, so in the meantime while we are thinking about testing we should use condoms. I tell him we can have a child and sex without a condom after we have tested negative.

Discussion

The magnitude of sexual violence among Basotho women is very high

This study found a high incidence of sexual violence among Basotho with 61% of the sample reporting having experienced at least one episode of sexual violence at some point in their lives. In the study sexual violence was divided into two categories: sexual coercion and sexual assault. Forty percent reported experiencing some form of coerced sex and 50% experienced some type of sexual assault at least once in their lives.

The types of coercion to engage in sex included fear of violent consequences, exploitation due to financial hardship, and threats posed by someone in a position of authority. Women's social and economic vulnerabilities put them at risk for coerced sex from teachers and employers and by men who can provide them with money or gifts._ Consent to unwanted sex due to fear of violence or other consequences was the most frequently reported type of coercion (20.5%). Approximately 17.8% respondents reported sex in response to a partner's continual arguments. The incidence of other coercive episodes, such as sex in return for transport or for money or gifts was reported by less than 10% of respondents.

Sexual assault was also common with 22% of the sample reporting being physically forced to have sexual intercourse at some point in their lives. A further 29% had been sexually groped against their will. In addition, 13% of women reported ever experiencing attempted forced sex. Forced sex or rape at sexual initiation was reported by 11% of women.

Women who have experienced sexual assault are also more likely to have experienced sexual coercion.

To allow comparison with sexual violence research conducted in South Africa, the present study utilized the same question to examine forced sex[5]. The rates of sexual violence reported in this study differ somewhat from those reported in South Africa, where rates of reported forced sex or rape at sexual initiation were 28-30% (Buga, Amokko & Ncayiyana, 1996).

[5] *The phrasing of the question is as follows: Has anyone ever forced or persuaded you to have sex against your will by threatening you physically, holding you down, or hurting you in some way? Refers to completed attempts.*

The types of coercion and assault experienced differs by perpetrator and characteristics of the woman

A number of socio-demographic factors were associated with sexual violence in this study in particular socio-economic status and education. Women with lower economic status and limited education were more likely to report sexual violence, while those with a higher level of education and higher socioeconomic status were less likely to have experienced sexual violence.

Young women in dating relationships are at great risk of sexual assault: 33% of respondents reported having experienced forced sex before the age of 18. Moreover, boyfriends were the perpetrators in nearly 66% of all occurrences of forced sex and in 44% of attempted forced sex. Although it is unknown whether the perpetrator was a former or current boyfriend, 41% of those with a steady boyfriend reported experiencing forced sex. Demographic and Health Survey (DHS) data in South Africa also shows that teenagers are at a higher risk of rape than the population as a whole (Jewkes, 2002). Reasons for this high incidence of forced sex among adolescents and young adults are unclear but may include male adolescent's early adoption of an adult value system that encourages sexual entitlement and men's preference for younger girls. This increased risk may also be a result of girl's early separation from protective forces such as their parents, which may lead to relationships with men at an early age.

Women without family support are at particularly high risk for sexual assault, such as those whose parent died in childhood or adolescence resulting in a loss of protection. Children who no longer have their parents may be required to work or to live with another family member or guardian. Previous studies have illustrated that women lacking social support are more susceptible to intimate partner violence (Ellsberg et al., 2000). Divorced or separated women are more likely to have experienced sexual assault in their lifetime, though it is uncertain as to whether the separation occurred as a result of the abuse or perhaps women become vulnerable when they lose spousal support. Moreover, women who were orphaned by one or both parents at an early age appear especially vulnerable to sexual assault. These findings are supported by recent research focused on the increased sexual vulnerabilities of orphans (Foster & Williamson, 2000).

The majority of women reported only one partner. Although women may decide to be monogamous, the normative practice for Basotho men is to engage in sex with other women while their wives are pregnant or menstruating (SAfAIDS, 2002). Again, for these women in committed relationships with men, there may be few, if any, options available to protect themselves from infection.

Types of sexual violence need to be defined locally

Research and programs that use the word "rape" likely miss most episodes of forced sex, since women in this study restricted the term rape to describe penetrative sexual assaults by a stranger. Respondents also reported that "rape" is limited to virgins, as 'experienced' women who are already sexually active cannot be "raped." A minority of woman surveyed felt that a woman can be "raped" by a husband or boyfriend,

Since an intimate partner perpetrated the majority of forced sex occurrences reported in this study, they do not fall under the common local classification of rape. In fact, if perpetrators were limited to strangers, the incidence of forced sex in this study would drop from 22.5% to about 3%, suggesting that the main obstacle to protecting women from sexual violence is not stranger "rape," but forced sex with intimate partners.

Previous descriptive studies in Lesotho have suggested that women may come to expect abuse in their lives and be socialized to tolerate and accept such adverse circumstances (SAfAIDS, 2002). Physical abuse from a husband is justified by the vast majority of survey respondents as a form of punishment for being disobedient and for minor infractions, such as failure to satisfactorily complete housework. Respondents spoke of the threat of physical abuse if they refused sex and most did not feel that a woman could decline having sex with her husband even if he mistreats her. Perhaps, as research in South Africa has highlighted, women tend to see physical and sexual violence as an inevitable part of dating relationships and marriage (Wood, Maforah & Jewkes, 1998).

Gender specific socialization serves to perpetuate and condone sexual violence. Respondents claimed that men had control over women, had a right to discipline them and, because of their insatiable sexual desires, had a right to force sex. On the other hand, women are blamed for being raped by dressing inappropriately, going out at night, drinking alcohol and attending places where it is served. Circumstances under which communities might grant compassion are those in which the woman adhered to the social standards but had been raped by a stranger or was raped as a young girl.

However, such cases of 'rape' still result in negative social consequences. Even when women are exonerated, they must cope with the stigma of having been raped. Women who are raped are gossiped about, tainted with scorn and laughter. Even the sympathy afforded to young girls is accompanied by the perception of the girl as 'spoiled.' Aware of these consequences, it is not surprising that a girl or woman forced to have sex by someone known to her would be reluctant to report the incident. Furthermore, survivors of sexual assault may keep their experiences private, to avoid being re-victimized by those around them.

Violence directed toward CSWs is reportedly condoned in areas of neighboring South Africa, where a study found that 41% of respondents believed that a prostitute should not file a police report if she were raped (Wojcicki, 2001). The community would not see women who accepted a drink from man and was later sexually assaulted by him as having been criminally assaulted.

Clearly, community response to disclosure of violence might influence a women's decision to report the incident(s), seek help and/or support. The community and family are more likely to be judgmental than supportive, and public perception of her is altered even in the few cases where the woman is perceived as blameless. In the words of one respondent, *"Because of these (reasons), women choose to keep quiet; they just wash their bodies and go to bed with their secrets."*

Community resources and interventions unknown or underutilized due to stigma

In general respondents faced a number of obstacles in making use of community resources and interventions in cases of sexual assault. Many respondents were reluctant to report incidents of sexual assault to the police due to the threat of maltreatment, lack of privacy and inappropriate and insensitive inquiries from officers. Another study revealed that Basotho police officers feel that they have insufficient training in dealing with survivors, a small number of female officers and a limited infrastructure such as interviewing rooms that would facilitate privacy (Chaka-Makhooane et al., 2002). However, a larger barrier to disclosing sexual assault is the stigma and public disclosure that results from reporting. When asked what would be helpful to women who had experienced sexual assault, only 1.3% of respondents suggested improved treatment from police, whereas 6.1% suggested more community support. If a sexual assault were reported, fellow community members would likely hear about it and, if the case proceeded, there would be open-court trial.

Other reasons why women did not report being sexually assaulted included the high cost of transport and medical exams. Over half of the respondents indicated that women needed assistance in medical costs, including the rape exam, medications (i.e., morning after pill, penicillin, etc.), and STD and HIV tests, incurred from a sexual assault. Counseling was cited by 29% of the respondents as important for women who had experienced sexual assault.

Some respondents familiar with SHARP! knew about the program's role in addressing sexual violence, but most understood SHARP!'s program goal to be focused on HIV education. Most program materials, such as posters, hats and t-shirts, reference HIV (i.e., red ribbon) rather than sexual violence. Since program materials are the most common form of program exposure, more could be done to included messages about sexual violence. Whereas only one-fifth of the program area sample had not heard of SHARP! services, many in the sample may have been exposed to their messages while not being aware of it's relationship to SHARP!. When prompted, respondents expressed considerable faith in the program's ability to prevent sexual violence.

Although, name recognition (i.e. SHARP!) is an important measure of program exposure, it could be that more women had been exposed to SHARP! program activities indirectly but had not associated these activities with SHARP!. For instance, awareness campaigns, or getting information from a friend who had spoken to a SHARP! peer educator are ways in which women could be exposed to SHARP! programs.

Sexual violence related to high risk behaviors

Women who reported sexual violence in this study were more likely to also have engaged in sexual risk-taking behavior as compared to women who did not report any sexual violence. Although, similar findings have emerged from studies conducted in industrialized countries, this is one of the few studies from a developing country context. Moreover, most studies on this issue had focused on child sexual abuse (CSA) and had failed to explore behavioral changes subsequent to adult sexual assault (Maman et al., 2000). Sexual assault in childhood or adolescence emerged as a significant predictor of teenage pregnancy. Forced sexual initiation was also reported as a risk factor for teenage pregnancy in South Africa where youth who were sexually assaulted at first sex were about 14 times more likely to be pregnant as a teenager (Vudule et al., 2001). Moreover, nearly 70% of the Basotho sample that experienced any forced sex before the age of 18 years were pregnant by the age of 18.

Women with a history of sexual violence, either assault or coercion also had a higher number of partners in the last 12 months than those without such experiences. While researchers in the U.S. have reported risky behavioral patterns among CSA survivors, it is unknown why such behaviors emerge. One possible explanation is that women who have experienced sexual assault might fear being alone and seek male partners to feel safe or some women may have reduced self esteem as a result of sexual assault, and seek comfort and a sense of worth from multiple partners. Clearly, more research is needed on the causes and dynamics of risky sexual behavior among women who have experienced sexual assault.

Women interviewed in program areas more likely to report sexual violence

Women interviewed in program areas were more likely to report certain coercive and assault experiences, such as consenting to unwanted sex due to their partners' continual arguments or because they were afraid of what their partner might do if they refused, forced to do something sexual, which they found humiliating or degrading, and experiences of forced sex. There are a number of possible explanations for this difference between program and non-program sites. First, women in program areas may have greater awareness of all the types of sexual violence as a result of exposure to the SHARP! program. As one SHARP! PE stated, *"They (potential survey respondents) would feel comfortable airing their views. They would want to see these problems come to an end. They want to be heard, to be exemplary to others."*

It is not uncommon to see increased reporting of health problems during an intervention. For example, a gender-based violence intervention in Venezuela resulted in a 44% increase in the number of clients who disclosed abusive experiences to their health providers (Otto-Oyortey, 2000).

SHARP! activities could have prompted some women to reexamine past sexual experiences. Once empowered, women could recognize and acknowledge certain

instances where their rights had been violated. The fact that the differences between program and non-program areas were consistent across a number of variables further suggests that the program did increase awareness. For example, more women from SHARP! program areas reported seeking legal services after an assault, a resource promoted through SHARP!.

However, given the limitations of the study design, it is not possible to conclusively attribute the differences to the SHARP! program. Other possible explanations include actual differences in levels of sexual violence. It is possible that the program purposefully targeted areas with higher levels of sexual violence. Finally, there may be other factors not measured in this survey that may explain the difference.

No difference were observed for community attitudes towards women's attitudes and beliefs regarding their role in the family, in relationships or in the community, suggesting that it may be easier to change an individual's attitudes and behavior than those of the overall community.

Women interviewed in program areas more likely to use condoms

Although about 90% of participants in both areas were aware of the protective value of condoms, program area participants were more likely to act on this knowledge. A higher proportion of program area respondents reported use of a condom in the last 30 days. While significantly different, the use of condoms is still not high, with only 20% of program area respondents reporting condom use. However, there was evidence to suggest that this proportion might increase since program area respondents reported more confidence in convincing their partners to use condoms.

No differences were found with respect to knowledge of HIV prevention methods, MTCT or AIDS myths. There may be due to the wide dissemination of information on HIV through billboards, media campaigns and numerous non-government organization in both program and non-program areas. In fact 5.4% of respondents in the non-program area were familiar with SHARP!.

This study revealed a number of gaps in knowledge. For example, one-third of all respondents report that a healthy looking person cannot spread AIDS. Another common misconception was that transmission could occur via mosquito bites. Awareness of the risk of passing the virus to children through breastfeeding was also low, particularly among program area respondents. Respondents also reported that sex with certain kinds of partners can cure HIV, while several reported that AIDS does not exist, and that their deaths were due to other known causes.

Programmatic recommendations

These recommendations are based on findings presented in this report, and on the resources and context of SHARP!.

♀ Continue and expand program on sexual violence

Findings illustrate that SHARP! addresses an important need and is perceived as a positive and effective program. Therefore SHARP! should continue to focus on sexual violence issues as part of its overall HIV prevention program and can develop meaningful goals and objectives for addressing this issue. SHARP!'s present focus on sexual violence is nonspecific. Development of specific goals and expected program outputs and outcomes would assist the program in focusing efforts and monitoring progress.

♀ Empower selected PEs to serve as local sexual violence resources

Selected PEs should receive training on rape reporting, medical and judicial procedures, as well as information about available community services (i.e., support groups).

♀ Continue to address sexual violence issues with youth

Targeting youth, especially male youth with messages on negative consequences of sexual violence are particularly important, since dating relationships seem to pose the greatest threat of sexual violence. Discussions and information that challenge traditional stereotypes are important as youth begin to develop norms regarding gender roles and relationship expectations.

♀ Use culturally appropriate classifications of sexual violence

Too often, sexual violence programs focus on rape. Messages about rape will not resonate with the vast majority of women who experience forced sex. Discussions pertaining to sexual violence should move beyond rape, to include forced sex and other forms of sexual coercion.

♀ Strengthen advocacy efforts and awareness of legal rights

Advocacy efforts to strengthen the legal structure and standardize sentences and procedures could build trust in the system and increase reporting of sexual assault. In addition, increased awareness is clearly needed, especially since many women reported uncertainty about how and where to report a sexual assault. Women often stated that they were unaware of any organizations responsible for assisting survivors of sexual violence.

♀ Concentrate program efforts within the community, not in formal service systems

Most women who reported having been sexually assaulted are not reaching the police station or hospitals, due to insensitive treatment and fear of public disclosure. SHARP! can work towards helping community members recognize all forms of sexual violence and to become committed to reducing its occurrence. At present, efforts focused within the judicial or health care system are likely to assist only the small number of individuals with the courage to seek out these services.

♀ Continue to develop promotional materials endorsing women's rights & support of survivors

About 95% of the respondents who were aware of SHARP! reported exposure to program materials, such as hats and t-shirts. These items provide more than program recognition. They provide reminders of the threat of HIV and, in some cases, the use of condoms. Messages surrounding sexual violence may have a similar effect and begin to corrode norms that sustain such volatile behavior. Appropriate slogans would need to be developed locally, but may include some of the following themes mentioned by SHARP! program staff and other concerned individuals: "Stop the violence," "I support, I don't judge," "I have the right to say no," and "Real men wait until she says yes."

♀ Tackle gaps in AIDS knowledge

Although general awareness of HIV is high, there are a number of specific gaps in knowledge that may be contributing to violence and transmission. Specific beliefs, such as the 'cleansing myth' and the idea that AIDS does not exist, need to be addressed. More people need to realize that a healthy looking person can carry the virus and that it cannot be transmitted from mosquito bites or common inanimate objects. Also evident are the gaps in knowledge surrounding MTCT and HIV transmission through breastfeeding, the symptoms of STDs, and the incubation period of HIV.

♀ Include males

Men or all ages need to be involved in programs aimed at preventing violent behavior through school life-skills programs, community theatre, media campaigns, and particularly men's groups.

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